Parkcare Homes (No.2) Limited

Melling Acres

Inspection report

Giddygate Lane
Melling
Liverpool
Merseyside
L31 1AQ

Tel: 01515492100
Website: www.craegmoor.co.uk

Date of inspection visit:
12 July 2016
15 July 2016
01 August 2016

Date of publication:
02 September 2016

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This unannounced inspection of Melling Acres care home took place on 12 July, 15 July and 1 August 2016.

Melling Acres had a comprehensive inspection on 14 July 2015 and was judged to be 'Good' overall. This inspection was undertaken in response to an increase in concerns raised about the service, in particular concerns that the service was not effectively managing the risks people living there presented with.

Situated in a rural location, Melling Acres provides specialist support and accommodation for up to 16 adults with profound complex needs associated with a learning disability and/or autism. Each person living there has support from a dedicated member of staff during waking hours. The accommodation is set in three acres of private gardens and woodlands and located two miles from the towns of Kirkby and Maghull. Accommodation includes Melling House that can accommodate up to seven men, Melling Lodge that can accommodate up to three people and Melling Mews, which consists of eight single-occupancy self-contained apartment style cottages.

At the time of the inspection there were 14 people living at the home. This number had reduced to 13 by the third day of the inspection.

There was no registered manager in post. They had left the service shortly before our inspection. A new manager had been appointed and they were planning to register. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People living at the home told us they did not feel safe and were scared of some of the other people living there. Women in particular did not feel safe as a man had moved into the accommodation that had historically been just for women. When the man displayed behaviour that was challenging the women and staff had to vacate the premises and wait outside to ensure their safety. The women living in this accommodation had not been consulted prior to the man moving in there.

People were not protected from abuse. There were recorded incidents where people had been subject to assaults from another person living there. Some of these assaults were serious in nature. In addition, numerous medicine errors had not been reported, and incidents had occurred when people were not receiving their correct level of support. Not all of these incidents had been referred to the local authority as safe guarding concerns. Staff were not up-to-date with adult safeguarding training. New staff had not received this training prior to supporting people.

The provider was not working in accordance with the principles of the Mental Capacity Act (2005) as unlawful restrictive practice (restraint) was being used by staff on some people living at the home. Deprivation of Liberty safeguards (DoLS) were in place for people in relation to restricting people to live at

the home with continuous staff supervision. The DoLS authorisations did not cover the use of restraint. Risk assessments and individual support plans were not in place regarding the use of restraint.

Individual risk was not managed effectively. Staff told us that when new people were admitted they received very little information about the risks the person presented with. Staff were working to old care records for a person who presented with significant behaviour that challenges and the file contained minimal information about the person. Risk assessments and a risk management plan were not in place for a person admitted three months ago. Support plans were not always adhered to. For example, we observed a person being supported to use a taxi in an unsafe way that was contrary to their support plan. The manager immediately addressed the matter and ensured the safety of everybody there.

We were advised of a number of serious incidents involving staff being assaulted by a person living at the home resulting in personal injury. Serious incidents had been 'downplayed' when reported by management. We checked two of the most serious incidents staff told us about. One incident had not been reported at all. The other incident was recorded in a way that minimised the seriousness of the assault. There was no evidence provided to suggest incidents were routinely being monitored and analysed in order to identify emerging themes.

The management of medicines was not robust and we found numerous errors in relation to the administration, provision, storage and monitoring of medicines.

Everybody living at the home had a minimum of one-to-one support during working hours. Mixed views were expressed about staffing levels. At times we observed a lot of staff about the home but staff told us there were other times when there were not enough staff to provide support. Agency staff were being used. There were new staff who had no prior experience of care work, had received a variable induction and had not received any training prior to supporting people. This meant there were insufficient numbers of staff with the appropriate skills and experience to support people safely.

Effective staff recruitment processes were in place. Relevant checks were carried out to ensure staff were suitable to work with vulnerable adults. Staff training was not up-to-date. The new manager confirmed that all staff had received supervision since they took up the post.

Risks associated with fire were evident. We found a fire door missing and were advised that it had been removed over a month ago by one of the people living there. It was replaced after the second day of our inspection. We also found the closure of another fire door had been removed and some fire doors did not close effectively. Personal evacuation plans for people had not been updated since December 2014.

People were supported by their dedicated staff to purchase their food and make their own meals and drink. We observed people had their own food store areas and these were well stocked. One person needed a lot of encouragement to get up and sometimes did not get up at all so went for very long periods without food or drink. There was no evidence that any action had been taken in relation to the person was going without food and drink for such lengthy periods.

Some staff were exceptionally kind to people. They took the time to ask people about their particular needs and what they wanted to do that day. They demonstrated a commitment to supporting people in a positive way and it was clear they wanted to make a difference to people's lives. Not all staff demonstrated this positive approach and we noted some staff were less encouraging in their approach when supporting people.

When a person with specific cultural needs moved to the home staff were not given any instruction in their culture so the person had been receiving support in a way that did not meet their needs.

Families expressed dissatisfaction with the cleanliness of their relative's accommodation and also expressed that their relative's personal care needs were not being effectively met. One family raised a concern that their relative's Motability car had been inappropriately used by staff.

Although there were pockets of good practice, the service overall did not follow the principles of person-centred care. There was no evidence in the care records that the person and/or people important to them were consulted when developing or reviewing support plans. We could not see that outcomes for each person, their capacities and the support required to meet their outcomes was identified. From our discussions with families, visiting professionals and review of care records we determined that meaningful activities based on people's preferences were not routinely happening for people.

Staff identified two people who did not like noise. Given that Melling Acres is a specialist service for people with autism and it is well acknowledged in the literature that people with autism can be sensitive to noise, the provider had not taken this into account when accommodating these people within the service.

Staff were aware of whistle blowing procedures but said did not feel they could escalate any concerns within or outside of the organisation because they believed there would be reprisals. We found evidence that the service was not operating in an open and transparent way.

A complaints procedure was in place and the manager provided details of a recent complaint that was in the process of being addressed.

Structures to monitor the quality and safety of the service were in place. These included a monthly audit by the regional manager, an internal regulatory audit and both weekly and monthly incident reporting. These systems were ineffective as improvements had not been made based on findings and concerns identified. Furthermore, the concerns we identified from the reported incidents had not been picked up.

Confidential files were not being held securely and we found people's care records were exposed in communal areas and the cupboard they should be stored in was not lockable.

The provider was not informing the CQC of all the events CQC are required to be notified about.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

•□Ensure that providers found to be providing inadequate care significantly improve
•□Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
•□Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed

could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

We are taking action to protect people due to the significant concerns found at this inspection and will report on our action when it is completed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.
People said they did not feel safe because they were scared of other people living there. Individual risk was not was being managed well. Staff were not always adhering to people's risk and support plans. Risk assessments and support plans were not in place for some people who recently moved to the service.

Medicines were not being managed in a safe way. We had concerns and found errors in relation to people receiving their medicines when they should, and receiving them in a safe way.

Sufficient numbers of suitably skilled, competent and experienced staff were not available at all times to ensure the risk presented by some people was managed effectively, and to ensure the safety of other people, including staff and visitors.

Arrangements to ensure people were protected from abuse and potential abuse were not effective. Not all staff had received training in adult safeguarding.

A fire door had been removed and we found the closure device had been removed from another fire door, which meant people would be at risk in the event of a fire.

Effective arrangements for the recruitment of staff were in place.

Is the service effective?

Inadequate

The service was not effective.

Staff training was not up-to-date. The induction of new staff was not consistent and some new staff had received a minimal induction. New staff had not received training as part of their induction.

People were supported to make their own meals. One of the people often stayed in bed all day and sometimes went without food and drink for very long periods. No action had been taken to address this.

The principles of the Mental Capacity Act (2005) were not being

adhered to because restrictive practices were being used unlawfully.

People were having their health care needs met but this was not always happening in a timely way.

Is the service caring?

Inadequate

The service was not caring.

A man had moved in accommodation that had historically been for women only. The women who lived there had not been consulted about this decision.

Some staff showed a caring and encouraging attitude towards people but not all staff demonstrated this positive approach.

Families were not all satisfied with the care. They felt their relative's personal care needs were not being met and that their relative was not being effectively supported to clean their accommodation. There was limited evidence to show that people and/or their representative were involved with on-going reviews of their care.

All the people living at Melling Acres had someone to represent them.

Is the service responsive?

Inadequate

The service was not responsive

The service overall did not follow the principles of person-centred care. We could not see that outcomes for each person, their capacities and the support required to meet their outcomes was identified.

From our discussions with families, visiting professionals and review of care records meaningful activities based on people's preferences were not routinely happening for people.

A complaints process was in place.

Is the service well-led?

Inadequate

The service was not well-led.

Systems to monitor the quality and safety of the service were not robust. These included checks and audits, and the incident reporting and analysis system.

The service was not open and transparent. Staff told us they were fearful of using whistle blowing procedures for fear of reprisal.

Care records were not always held securely.

CQC had not being notified of events the provider is required to inform CQC about.

Melling Acres

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.'

This unannounced inspection was undertaken on 12 July, 15 July and 1 August 2016.
The inspection team consisted of two adult social care inspectors, a pharmacist specialist and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the home. We looked at the notifications and other information the Care Quality Commission had received about the service. We contacted health and social care commissioners and providers to obtain their views of the service. The concerns identified were incorporated into the inspection plan.

During the inspection we spent time with five people who were living at the home and spoke with three family members by telephone. We also spoke with the service manager, regional manager, the operations director, head of quality, positive behavioural specialist and the housekeeper. In addition, we spent time with three senior support workers and 12 support workers, one of whom was employed by an agency. We spoke with an independent advocate and a social worker during the inspection.

We looked at the care records for six people and the medicine records for six people. We also reviewed four staff recruitment files and records relevant to the quality monitoring of the service. We looked round the premises and observed staff supporting people.

Inadequate

Is the service safe?

Our findings

We asked people whether they felt safe living at the home and the response was mixed. Two people told us they were scared of other people living there. Women in particular said they did not always feel safe. This mainly related to the Melling Lodge; accommodation that historically was just for women but a man had been living there since January 2016. A woman who lived in the Lodge told us they did not feel safe and said, "I don't like the man being here. He looks at me and I feel uncomfortable."

Staff told us the man was inappropriately placed in the Lodge with women because of the risks he presents to other vulnerable people. They said that when the man displayed behaviour that was challenging inside the Lodge then the women and staff had to vacate the premises and wait outside to ensure their safety. This practice of vacating the Lodge was confirmed by an incident report from 29 June 2016 that also involved the police being called to the service. Staff told us they did not have the necessary skills and experience to manage the level of risk this person presented with. A member of staff said, "It is not a safe service with some residents. They are not appropriately placed. They should be somewhere else where their needs can be met."

Staff told us they received minimal information when new people moved in to Melling Acres recently. With reference to one person with very complex needs a staff said, "We learned along the way what to do if [description of behaviours] happened. I had to learn how to support him myself." Another staff told us, "We don't know the level of risk. We don't have all the information or the proper care plans." A member of staff also said in relation to all the people living there, "There's a lack of background information and support plans [available]."

We asked to see the care records for a person with very complex needs and who presented a risk to others. There was very limited information available in terms of assessment, including risk assessments and risk management plans. We could see that these records were active as information had recently been reviewed by staff. On the second day of the inspection we were provided with another care record file for the person that was more current and detailed in terms of managing risk. However, this was unsafe as it meant staff had been working to an old care record file and therefore had access to limited information about the person.

We were advised of a number of serious incidents involving staff being assaulted by a person living at the home resulting in personal injury. Staff told us serious incidents had been 'downplayed' when reported by management on the electronic incident reporting system. A staff said to us, "Things get brushed under the carpet." We checked two of the most serious incidents staff told us about. One incident resulting in a staff receiving a serious facial injury had not been reported at all. The other incident was recorded in a way that minimised the seriousness of the assault. There was no evidence provided to suggest that incidents were routinely being monitored and analysed, which meant any emerging themes or patterns were not being identified in order to learn lessons and minimise the reoccurrence of similar incidents.

Although personal alarms, used as a safety measure for staff and others were available, staff confirmed they were not being used. We reported on this same matter when we inspected the service in December 2013.

Similarly, at that time staff were supporting people with high levels of behaviour that challenges and the personal alarms were available but not being used. This shows the provider was not learning lessons from the outcome of inspections in order to maximise the safety of staff and others.

Families told us they were worried about safety at the service. A family member expressed concern that their relative had been taken out in the car with just one staff when there should have been two. They said this was unsafe. Another family member said to us, "I have some real concerns for the safety of [relative]. I just want to get them out of there." Families told us they did not think that staff had the relevant experience, training and skills to support their relative safely and effectively.

From our scrutiny of the reported incidents, we noted incidents involving people assaulting staff while being transported in either a mini-bus or car. We raised concern about incidents occurring in vehicles at previous inspections in December 2013 and June 2014 as this is not only a risk to the person, driver and other staff but also a risk to the public. Following those inspections, risk management plans in relation to transport were put in place. However, we did not see at this inspection that these plans had been reviewed following incidents in the vehicle. An incident occurred in the vehicle on 29 May 2016 whereby a person tried to assault staff and open the car door while it was moving. An incident form was completed but there was no evidence of it having been recorded electronically.

A member of staff told us that they had been advised by the previous manager that one of the people whose risk assessment stated they needed two staff when in a vehicle could go for a drive with just one member of staff. The staff said this arrangement was still in place despite the person assaulting the driver while in transit on 20 January 2016. This shows that the provider was not learning lessons from the outcome of inspections in order to maximise the safety of staff and others. Although this incident was recorded in the person's care records and the staff said they completed an incident form, it was not recorded on the electronic recording system. This, along with other concerns we found in relation to the reporting of incidents, shows that incident management arrangements were not effective.

Our concern about safety involving the vehicles was highlighted to the manager, regional manager and operations director after the first two days of the inspection. A person had a support plan in place stating he was not to sit in the front of the vehicle at any time. An incident involving the person resulting in property damage had occurred just before we arrived on the third day of the inspection. Later that morning the inspection team witnessed the person going out in a taxi sat alongside the taxi driver with their support staff in the back. We immediately raised this with the manager who telephoned the support staff and the taxi was stopped; the person was transferred to the back seat. This showed the person's support plan was not being followed and that lessons had not been learnt from the first two days of the inspection.

We also observed from the reported incidents that restraint was used on a number of occasions to manage behaviour that challenges. For example, it was recorded on the electronic reporting system that a person had "seating restraint" on 3 April 2016. Another incident form showed that a person had "full restraint" on 29 May 2016. This incident was not recorded on the electronic reporting system. We checked the care records for the person. Although positive behaviour support (PBS) plans were in place, these primarily focussed on proactive strategies. The section on reactive (tertiary) strategies, such as the use of restrictive practices was limited and there was no assessment or plan in place in relation to the use of restraint. This matter was previously identified at the inspection in June 2014. This meant the approach to restraint was not in accordance with national guidance, which highlights that restraint should be individualised and subject to regular review.

It was not clear whether staff were trained to undertake 'restraint' and by the third day of the inspection we

confirmed, through discussions with staff, the manager and review of training records that staff were trained to use breakaway techniques but not trained to restrain a person. A member of staff said they had to "heavily modify" their training in order to use restraint to manage challenging incidents. By staff using restraint when they had not been trained to do so, and in the absence of an individualised restraint plan, meant the person's safety had been put at risk through the use of inappropriate restraint techniques.

This was a breach of Regulation 12(1)(2)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that people were not protected against the risks associated with the unsafe use and management of medicines. We looked at medication records for six people living at Melling Acres and found concerns relating to medicines for all those people.

Medicines were not always stored securely. We found keys to medicines cabinets and stores of newly delivered medicines were accessible to support workers who were not authorised to handle medicines. We found medicines and creams that were unlabelled, meaning we could not be certain what the products were, who they had been prescribed for or how they were to be given. The health and wellbeing of people living at the home is at risk of harm when medicines are not kept safely.

People were not always given their medicines when they needed them or in a safe way. People frequently missed being given their medicines as they had chosen to get up late or go to bed early. One person often refused their medicines but there was no care plan in place to guide staff in the best way to encourage the person to take their medicines as prescribed. We saw one person had been given two doses of paracetamol within an hour because support workers had failed to document the first dose. This placed the person at risk of paracetamol toxicity and unnecessary side effects.

All of the people in the sample we looked at were prescribed one or more medicines that were to be taken when required. We found that staff did not have enough detailed information available to give these medicines safely. We found there was no information recorded to guide staff which dose to give when a variable dose (e.g. one or two tablets) was prescribed. It is important that this information is recorded to ensure people are given their medicines safely and consistently at all times.

Medicines were not always available for use. We found that one person whose skin appeared red and sore had run out of two of their creams and medicated skin wash, and had not had any available for over two weeks. Details about a third prescribed cream had not been transferred to the current medication administration record and so staff were no longer using it. One person had recently had a dose of sleeping tablets changed from being used every night, to being used only when required. However, we saw that staff had returned the medication to the pharmacy in error, meaning that there was none available should the person need them. People's health and wellbeing is at serious risk of harm if they do not get their medicines when they need them.

Staff who gave medicines were not all trained to do so and no assessments of competence had been carried out to ensure staff could carry out this task safely. Following our feedback after the first two days of the inspection, the provider brought in a qualified agency nurse to oversee medicines in order to reduce the risks. Because the nurse was not on duty at all times, unqualified staff were still responsible for giving medicines on some occasions so the risk had not been minimised sufficiently.

One person had a specialist emergency medicine to treat seizures associated with epilepsy. We were advised the person had one seizure per week on average. The instructions for the use of the medication

were conflicting and we could not tell exactly how this medication should be used. Although staff carried this medicine with them at all times, not all of them knew how or when it should be used. This placed this person's health at serious risk of harm.

This was a breach of Regulation 12(2)(f)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the incident reports from January 2016 alongside the adult safeguarding referrals made to the Local Authority during the same time frame and identified a large number of incidents that should have been reported by the service as safeguarding concerns but had not. These included assaults by people living in the home on other people living there and numerous medication errors. In addition, we noted that incidents had occurred when people were not receiving the correct level of support and they had not been treated as safeguarding concerns. Not appropriately safeguarding people was identified at the inspection we undertook in June 2014. Some staff we spoke with were not sure of the arrangements for safeguarding people and recently recruited staff had not received safeguarding training before they started to support people. This meant effective processes were not in place to ensure people were protected from abuse.

This was a breach of Regulation 13(1)(2)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked around the premises to check the environment and equipment was safe. Two families told us that their relative's accommodation was not always clean and both had recently cleaned the accommodation themselves. Some people did not wish for us to look at their accommodation but the accommodation that we did see was clean, tidy and generally well maintained. The 'Safe' domain was rated as 'Requires improvement' at the inspection in July 2015, in part because we found three closure devices had been removed from fire doors. Lessons had not been learnt following that inspection as on the first day of our inspection we found a fire door missing in Melling House. Staff told us one of the people had broken the fire door down over a month ago. The fire service had not been informed; nor had a risk assessment been undertaken in relation to risks associated with the missing fire door.

We checked the fire doors on the third day of our inspection and the missing fire door had been replaced. However, we found that that the closure device on an identified fire door had been removed. We also found two other fire doors did not fit correctly so would not be effective in the event of a fire. An external fire risk assessment was undertaken in November 2015. The service was rated as 'moderate' and this partially related to ineffective fire door closures. Personal emergency evacuation plans (PEEP) were in place for people, except the people who had recently moved in. The majority of PEEPs had not been reviewed since December 2014.

This was a breach of Regulation 12(2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The views expressed by staff and families about staffing levels were variable. The people living at the home all had a minimum of one-to-one staff support during the day and many had the support of two staff when accessing the community. Staff consistently told us that the staffing levels had not been good, which restricted people living there from going out on a regular basis. Staffing rotas from May and June 2016 showed two-to-one staff support was not always identified for people who needed it. Staff said staffing levels had improved recently, mainly through the use of agency. New staff had been recruited but three of them told us they had not had prior experience of care work and had not been given the necessary training prior to supporting people. This meant people were not being supported by adequate numbers of suitably

skilled and competent staff.

This was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked a selection of personnel records for staff recently recruited and could see that recruitment checks had been carried out to confirm the staff were suitable to work with vulnerable adults. References had been obtained for each member of staff. Photographic identification had been taken but these were of poor quality.

Inadequate

Is the service effective?

Our findings

We looked at whether the service was adhering to the principles of the 2005 Mental Capacity Act (MCA). This legislation provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The manager had a system in place to monitor the DoLS for people, including when they were due to expire and when best interest reviews were due. The manager confirmed that DoLS authorisations were in place for people in relation to restricting people to live at the home with continuous staff supervision. From our conversations with commissioners it was clear that they coordinated DoLS best interest reviews for the people they had placed there. The DoLS authorisations did not cover the use of restraint, which we established was being used by staff to manage challenging situations. We did not see that mental capacity assessments had been undertaken and that best interest discussions had taken place regarding the use of restraint. This meant restrictive practices were being used unlawfully.

The people living at Melling Acres had their money managed within the home systems. We did not see mental capacity assessments or best interest agreements to indicate each person had consented to this arrangement.

This was a breach of Regulation 11(1)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with said they had not received supervision and/or appraisal for some time until the new manager took up post. A staff said to us, "We weren't having supervisions but we've got to have them now." Senior support workers told us they were now undertaking supervision with the support workers. The manager advised us that they had met with all staff to assess their performance and development needs and were confident that they had a good understanding of the needs and capabilities of individual staff members. All staff we spoke with said they felt more supported in the workplace since the new manager started. A member of staff told us that they had their annual appraisal 'signed off' some months back but that no appraisal had actually taken place.

We spoke with three recently recruited staff and an agency staff and asked them about their induction. The agency staff had worked there a few times and said their induction was good. They described being shown around the service and informed of fire arrangements. They said they were given an overview of the person they were supporting, including any risks and were given time to read the care records for the person. The recently recruited staff had no prior experience of care work. They described a variable induction. For example, one staff had a week of shadowing a more experienced staff but another had just two days of

shadowing. They were given the care records to read but one staff said they had no prior knowledge about risk assessments and care plans and nobody explained what they were used for. All newly recruited staff said they had not received any training since starting the job. There was no evidence to suggest that new staff were working to the Care Certificate. This is a minimum set of standards that should be covered as part of induction training of new care workers.

Staff told us they were not satisfied with the training because it was electronic and they could not ask questions or check things they did not understand. This same concern about electronic training had been raised by staff at the inspection in June 2013. In relation to the recent change of manager, a staff said, "There's a push towards more face-to-face [training]." Staff also told us they were not up-to-date with their training. The training monitoring record we were provided with showed gaps in training subjects the organisation required staff to complete. This included gaps in managing behaviour that challenges, moving and handling, nutrition, infection control and privacy and dignity training. This meant people were being supported by staff who had not received appropriate training to carry out the duties they were employed to perform.

This was a breach of Regulation 18(1)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported by their dedicated one-to-one staff to ensure they received food and fluids in accordance with their preferences. Some people prepared their meals with the support staff or staff prepared meals for people who were unable to do so or did not wish to do so. We did not have an opportunity to observe individuals being supported preparing their own meals but we did see people preparing drinks frequently throughout the day. We observed from the care records we looked at that people had a dietary plan in place and went shopping with staff for their food. We looked at the food stores in Melling House and observed that each person had their own fridge and freezer shelves.

We reviewed the June 2016 daily records for a person and noted that there were some days when the person would not get up so therefore did not have food and drink for long periods. For example, the records showed one day when the person had no food or drink from 8.00am until 11.00pm. There was another day when the person went without food and drink for 13 hours. There was no evidence that a risk assessment had been completed, that it had been considered in accordance with the Mental Capacity Act 2005 or that specialist health care advice had been sought.

This was a breach of Regulation 14(1)(3)(4)(a)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We could see from the care records that people attended health care appointments when they needed to. These included appointments with their GP and specialist service services, such as mental health. A record of consultations with health or social care professionals were recorded in the care records. Some months prior to the inspection a family had contacted CQC concerned that a specific health need their relative had was not being addressed. We checked on up on this and staff confirmed that the person had received treatment and their health condition had improved. Shortly before the inspection another family member contacted CQC advising that a health need of their relative was not being met despite numerous requests. Although it had taken time, the manager confirmed that the person had now been referred to the appropriate health care professional.

The manager also advised us that they planned to introduce health action plans for each person. This was surprising as health action plans had been in place for people at previous inspections but were no longer

available in the care records we looked at. A health action plan is an individual plan about what a person needs to do to stay healthy. It identifies support the person may need in order to stay healthy.

Inadequate

Is the service caring?

Our findings

We asked people living at the home their views about how staff treated and engaged with them. The views were mixed. One person said, "I love the staff here. They really treat me good." Another person told us, "I feel safe and happy with some staff but not all [staff]." A person also said to us, "Some of the staff wind me up at times and I don't like it. They make fun of me."

We observed staff who were exceptionally kind to people. They took the time to ask people about their particular needs and what they wanted to do that day. This was done in an upbeat and enthusiastic manner. Their attitude demonstrated a commitment to supporting people in a positive way and it was clear they wanted to make a difference to people's lives. Not all staff demonstrated this positive approach and we noted some were less encouraging in their approach. For example, one of the people needed a large amount of encouragement most days to get up. Some staff tried various ways to encourage the person to get up, such as suggesting an activity they knew the person liked. Other staff just knocked on the person's door and asked the person to get up. They did not use the opportunity to engage further when the person refused. A member of staff said to us, "Some staff don't try hard enough to get [person] up." This was confirmed by how the staff recorded their interventions in the person's daily records.

Feedback from families was mixed regarding whether staff were caring towards their relatives. One family was more than happy with how staff supported their relative. However, two families were not so satisfied. Both expressed concern at the unclean state of the accommodation they found their relative living in and said their relative's personal care, and cleanliness of their clothing was not as good as it should be. One of the relative's said they got an inappropriate response when they queried why staff were not routinely cleaning their relative's accommodation. They said the response was, "Well, what would you expect with all male carers."

One of the people living at Melling Acres had a Motability car. Their family advised us that the car had been used to take another person out. They also said that a member of staff had used the car on one occasion for personal reasons. This showed a lack of respect for the person's property. The manager advised us that this could no longer happen as they had put in a system of logging the vehicles in and out so that it could be monitored when and how the vehicles were being used.

The women living in Melling Lodge were not happy that a man was living there. This accommodation historically had been for women only and the women's views had not been sought regarding a man living in their accommodation. There had been times when the women had to leave their home and wait outside because the man was disturbed. This shows that reasonable measures had not been taken to ensure the privacy and dignity of the women was maintained at all times.

This was a breach of Regulation 10(1)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at care records to see how people were enabled and supported to participate in making

decisions about their care, including involvement in their care reviews. This was variable. The care records for two people showed no meaningful involvement of either the person or a family member. For example, there were no care plans signed by the person or their family to show they had been involved. We saw in another care record that the person was actively involved and, in preparation for a care review, the person had completed a document about his views of the service. It clearly recorded a preference to move somewhere else and the person recorded, "Not the right place for me." In addition, the person recorded, "Dislike some staff." It was not clear from the records whether the review had taken place and whether these expressed views of the person were being taken into account. Staff told us people or families were not routinely involved with care reviews. A member of staff said, "Service users are not involved in their support needs. Things are being done for them."

This was a breach of Regulation 9(3)(d)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All the people living at Melling Acres had someone to represent them if they needed it. Most people had family and those who did not had advocates.

Inadequate

Is the service responsive?

Our findings

We asked people living at the home how responsive staff were when supporting them in the way they desired, including support to meet their needs and to be independent. The views expressed were mixed. Some people were happy in the way staff supported them. A person said, "They know me well. They know my care plan." Another person told us, "The staff help keep me busy. I've done some painting and built some bird boxes and rabbit hutches." Other people said certain staff were not as supportive as others. For example, a person said, "Some staff help me to be independent. It depends who's on [duty]."

From our discussions with staff and review of the care records, we established that person-centred values were not embedded in practice. There were pockets of good practice. For example, we heard good examples of how people were supported to go on holidays to places of their choosing last year. One of the people asked to have a holiday in London this year and staff were in the process of organising the trip. However, the care records we looked at did not show that people's support was consistently developed and coordinated in accordance with the principles of person-centred planning. For example, there was no evidence that the person and/or people important to them were consulted when developing support plans. We could not see that outcomes for the person, their capacities and the support required to meet their outcomes was identified.

Prior to the inspection we had received information to suggest that a person's cultural needs were not being met. In accordance with their culture, the person had a special diet. Staff had not been adhering to the principles of the diet prior to the inspection as they did not fully understand the nature of the person's culture or diet. The manager advised us this had been addressed with staff. We checked the person's food stock, daily records and spoke with the manager so were assured that the person's dietary needs were now being met. However, two staff we spoke with were still not clear about the specific cultural needs of the person. They said they were not instructed in the person's needs at any point before their arrival and that guidance had been limited since. Staff told us they had received training in diversity and equality but that it was too broad to focus on the specific needs of different cultures.

We checked the person's care records. There was information downloaded from the internet about the person's culture. However, there was no support plan in place regarding the purchase, storage and preparation of the person's food. There was no support plan in place to provide staff with guidance on how to support the person with activities that met their cultural needs. In addition, the person's personal profile and life story was incomplete.

A person living in Melling House and told us the noise levels were too high. They told us they wanted to move from Melling Acres and said, "Can I go somewhere more quiet please." We observed from the person's daily records that they had on a number of occasions requested to move. We noted from an entry in their daily records that the person would not come out of their room one day because it was too noisy.

Staff advised us about another person who lived in Melling House and said, "He doesn't like crowds or noise. It upsets him." On the second morning of our inspection we observed a lot of staff and activity in the House

and we queried this as it did not support a quiet and calm environment. Staff said the people they were due to support that day were not up yet. Later in the afternoon we saw three staff in a person's mews accommodation. Two staff were available to support the person if they wished to go out (they didn't) and the third staff was new, and shadowing the other staff as part of their induction. We queried whether the amount of staff in people's accommodation could create too much stimulation/noise leading to an increase in behaviours that challenge. Given that Melling Acres is a specialist service for people with autism and it is well acknowledged in the literature that people with autism can be sensitive to noise, the provider had not taken this into account when accommodating and supporting people within the service.

Two of the families that we spoke with said they were concerned that there were insufficient meaningful activities for their relatives. A family member said, "We are worried about the lack of quality of activities." The independent advocate and social worker also were of the same view and confirmed social activities were not meaningful for some people. A staff member told us that until recently "staff just did their own thing". They said, "If staff did not want to go out [on activities with people] then they would not go out." We checked the June 2016 daily records for a person. There were few activities recorded and they just included trips for food shopping, a walk to the park and walks around the grounds. Staff confirmed that until the new manager started recently people were not receiving their planned activities. A member of staff said, "It is getting better now since [manager] and [deputy] came. Service users are going out on activities again. Some service users had got into a routine of staying in bed."

Staff told us that sometimes activities were delayed or could not happen because money was not available. A member of staff said, "Access can be difficult sometimes. We know when it is running out but we don't always get the money when we need it." The manager told us that training to access people's money had to be completed, which had caused delays. In keeping with the principles of person-centred values, we queried why independence was not being promoted by people having their own bank account coupled with support to access and manage their money.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A complaints procedure was in place and we saw an example of a formal complaint that the manager was addressing in accordance with the procedure. Staff told us that meetings titled 'Your Voice' were used to seek feedback about the service. We looked at the record of one of the 'Your Voice' meetings. The discussion focussed on individual goals and aspirations rather than seeking feedback about the service. The manager advised us that feedback questionnaires were distributed but we did not ask to see the most recent survey at this inspection.

Inadequate

Is the service well-led?

Our findings

A registered manager was not in post as they left the service in May 2016. Since December 2013 the service has had three registered managers. A new manager started five weeks before our inspection and was planning to register with CQC.

We asked staff their views of the management and leadership of the service. They were highly critical of how the service had been managed over the last 10 months, which many of them described as a bullish and intimidating management style. A staff said, "It went downhill due to the previous management." Another staff told us there was no leadership and said, "Staff were just doing their own thing." Staff said they felt unsupported and that communication, including handovers between shifts had been poor. We heard the service often functioned on low staffing levels and that people did not receive their funded hours to participate in activities. A member of staff said to us, "Staff were unhappy and either went sick or left altogether." When asked what they thought needed to change about the service a member of staff said, "The culture needs to change." They clarified this by suggesting that staff need to stop "running the show". Another staff said, "The whole focus of the service needs changing."

Staff told us they did not feel they could escalate their concerns within or outside of the organisation because of possible reprisals. They said that following a staff whistle blowing to CQC, they were told that the identity of the whistle blower was known and that the staff who blew the whistle would be "sorted". Staff were advised not to contact CQC again. We checked our records and the last whistle blower to contact CQC was in November 2015. Furthermore, the police reported an incident to safeguarding that occurred on 6 May 2016. The provider notified CQC of the incident and the account of events differed significantly to that of the police. These examples along with other evidence found in relation to not reporting or 'downplaying' incidents meant the service was not operating in an open and transparent way.

Staff told us morale had been low but was gradually getting better because the new manager and deputy manager were making positive changes. With reference to the new manager a staff said, "She has had a positive influence. She clearly defined my job role. She has given us direction. She's brought stability to the team. She understands autism and has introduced a system for monitoring people's progress. Every morning we have a senior's meeting and are given tasks." Another staff said, "Under the new management it feels like we're going in the right way. It used to be a chore because of the people above you but their [manager's] door is always open now. [Manager] and [deputy] are doing as much as they can. They see the problems."

Internal quality assurance monitoring systems were in place and had identified many of the concerns we found. We looked at the service reviews carried out by the regional manager on 16 November 2015, 19 January 2016 and 26 May 2016. All those reviews identified concerns with the cleanliness of people's accommodation yet improvements had not been made as families raised concern about the cleanliness during the inspection. Even though the absence of plans for giving 'when required medication' was raised at the service review in January, we found these plans were either unclear or still not in place. Staff training was identified in January as not up-to-date and we found the training was still out-of-date. The service review in

May highlighted that outcomes and clear goals for people were not identified in support plans.

An internal regulatory inspection was undertaken on 5 May 2016 and the findings from that also correlated with some of our findings, such as people and families not involved in reviews, poor recording of incidents and staff not up-to-date with training. We were advised that weekly and monthly electronic incident reports were produced for each region. We were shown examples of these reports and how a specific service and topics, such as safeguarding referrals or the use of restraint could be isolated for monitoring and analysis purposes. However, these systems were ineffective as improvements had not been made based on internal findings, and the concerns we identified from incident reporting had not been picked up.

When looking around the premises on the first day of the inspection we found confidential files about people living at the home were not stored securely and were exposed in communal areas. This meant unauthorised people could access information about people. We highlighted this to the manager at the time of our inspection. We observed that confidential files about people were still accessible in communal areas on the third day of our inspection, which showed lessons had not been learnt from our earlier feedback.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the completed incident forms in the home and also reviewed the adult safeguarding referrals to Sefton Social Services alongside statutory notifications received by CQC. It was clear that CQC had not been informed of events the provider is required to legally notify CQC about. These included notifications when a DoLS had been authorised for a person. Not notifying CQC of DoLS authorisations had been identified at the internal regulatory inspection in May 2015.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2014.

We discussed with the manager their views of the service and their plans to improve it. In the short time they had been in post, the manager had produced a turnaround plan. It acknowledged concerns with standards of care, staff performance, dissatisfaction from commissioning authorities, institutional practices and lack of leadership. It proposed a restructure of the site, revised management structure and improved accountability at all levels. Following the inspection, the manager confirmed that the plan had been agreed by the executive board.

The manager advised us that they had already started to make changes to the service. They routinely called to the service at various times so they could check what was happening out of regular work hours and spend time with the night staff. The manager confirmed that all staff had received supervision. The manager had spoken with families, care managers and commissioners, and person-centred reviews were being organised for the people living at the home. The funded hours were being monitored to ensure people were receiving the hours of support they should have. Daily meetings were being held with senior support workers to improve communication and ensure staff knew what they were supposed to be doing. A logging in and out of the mini buses and Motability cars had been introduced to avoid misuse of the vehicles.

The ratings from the inspection July 2015 were displayed as it is a requirement to do this within 20 days of publication of a CQC rating.

We gave feedback to the provider after our first two inspection days. We returned for a third day to continue the inspection and to check what improvements had been made. The operations director advised us that the provider recognised there had been a governance failure and that this was under investigation. They

also told us that personnel changes had been made within the senior management operational and quality monitoring structure for Melling Acres.

The manager said the new operational model for Melling Acres was being implemented. The human resources team was involved as the model would have an impact on the current role of some staff. Human resources were also involved in reviewing staff performance. Recruitment of staff, including the recruitment of three deputy managers was underway. Additional staff had been put in place for the person who presented the most risk to other people. At service level more robust procedures had been put in place in relation to the management and monitoring of incidents. The personal alarms were awaiting new batteries before being put back in circulation. Plans were in place for staff recruited in the last 12 months to complete the Care Certificate.

After the third day of the inspection we were advised by the provider that four experienced staff would be on duty each day at the service. The provider confirmed that 32 members of staff would receive training in restraint by 5 August 2016.